

Case Number:	CM13-0043126		
Date Assigned:	12/27/2013	Date of Injury:	05/14/2013
Decision Date:	04/28/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a hospital worker who submitted a claim for right sided traumatic and pain disorder from an associated industrial injury on May 14, 2013. Treatment to date has included pain medications and chiropractic treatment. Based on the medical records, the patient started to complain of pain at the cervical area radiating to the shoulders, right knee, and lower back after slipping on a wet floor. Cervical x-rays revealed an old fracture at C4 level. Pain is not relieved by medications such as Norco, Ketoprofen, and Neurontin. The patient claims that he has difficulty sleeping. Upon examination, the patient had difficulty getting up to the examining bed and there was pinpoint tenderness at lower back. Lumbar and cervical spine range of motion was noted to be decreased.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

RETROSPECTIVE CHIROPRACTIC TREATMENT TIMES 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

Decision rationale: As stated in the Chronic Pain Medical Treatment Guidelines, manipulation is recommended for chronic pain is caused by musculoskeletal conditions. Manipulation for the low back is recommended with a trial of 6 visits; with evidence of objective functional improvement, a total of up to 18 visits may be recommended. In this case, the patient presents with significant musculoskeletal conditions affecting daily functions. The functional gains acquired from previous chiropractic treatment were not clearly documented. In addition, the request does not specify a body part to be treated. The overall number of visits completed to date was not related to specific functional gains. Therefore, the request for retrospective chiropractic treatment is not medically necessary.